Status:	As Filed (Provider Version) --	X	Desk Reviewed --	
	Revised Desk Reviewed --		Field Audited --	

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2005 HOSPITAL BASED RURAL HEALTH CLINIC

1. Name and Address					Provider Numbers	Date Certified
Name of Facility:						
Street or P.O. Box:						
City:		State:		Zip:		
County:		Telephone No:				
2. Cost Reporting Period	From:		To:			

3. Type of Control	a. Voluntary Nonprofit		b. Proprietary	
	1. Corporation		3. Individual	
	2. Other (Specify)		4. Corporation	
			5. Partnership	
			6. Other (Specify)	
	c. Government			
	7. Federal		10. State	
	8. City/County		11. City	
	9. County		12. Other (Specify)	

4. If we have questions regarding the cost report, who should we contact?				5. If the Notice of Program Reimbursement Settlement should be mailed to other than the facility, please list the name and address.			
Name:				Name:			
Address:				Address:			
City:				City:		State:	
State:		Zip Code:		Zip Code:			
Contact Name:							
Telephone:							
E-Mail:							

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY that I have read the above statement and examined the accompanying schedules prepared by _____ for the cost report period beginning _____

(Name of Facility)

and ending _____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the facility in accordance with applicable instructions, except as noted.

Signature _____

(Officer or Administrator)

Title _____

Date _____

CORE PROVIDER NO.	ANALYSIS OF DIRECT CORE COSTS 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	(1)	(2)
1. Total Direct Cost (Medicare Cost Report, Worksheet A, Line 60.01)*		
2. Less: Other Ambulatory Services (Non-Core)**		
a. Pharmacy		
b. Dental		
c. Healthcheck Services (Formerly EPSDT)		
d. Maternity Care Coordination		
e. Child Services Coordination		
f. Radiology Services (on-site)		
g. Norplant Services		
h. Physician Hospital Services		
i. Other (Specify)		
3. Total Cost of Other Ambulatory Services (Sum Lines 2a - 2i)		
4. Net Direct Core Costs (Line 1 - Line 3)		

(DMA-HB3, Line 1a)

* Use data from the line in which this Rural Health Clinic was included on the Medicare Cost Report. If there are multiple Rural Health Clinics at the Hospital, their data may be combined or a separate Medicaid RHC Cost Report may be completed for each clinic.

** From Provider Records

CORE PROVIDER NO. _____	ANALYSIS OF ALLOCATED CORE COSTS 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	Total Cost	Allocated Core Ratio (From Line 5)	Allocated Core Cost (Col. 1 x Col. 2)
	(1)	(2)	(3)
1. Allocated General Service Costs (Medicare Cost Report, Worksheet B, Part 1, Line 60.01)*			
a. Old Capital-Related Costs - Buildings & Fixtures (Col. 1)			
b. Old Capital-Related Costs - Moveable Equipment (Col. 2)			
c. New Capital-Related Costs - Buildings & Fixtures (Col. 3)			
d. New Capital-Related Costs - Moveable Equipment (Col. 4)			
e. Employee Benefits (Col. 5)			
f. Administration & General (Col. 6)			
g. Maintenance & Repairs (Col. 7)			
h. Operation & Maintenance of Plant (Col. 8)			
i. Laundry & Linen (Col. 9)			
j. Housekeeping (Col. 10)			
k. Dietary (Col. 11)			
l. Cafeteria (Col. 12)			
m. Maintenance of Personnel (Col. 13)			
n. Nursing Administration (Col. 14)			
o. Central Service & Supply (Col. 15)			
p. Pharmacy (Col. 16)			
q. Medical Records (Col. 17)			
r. Social Services (Col. 18)			
s. Inservice Education (Col. 19)			
t Nonphysician Anesthetists (Col. 20)			
u. Nursing School (Col. 21)			
v. Interns & Residents (Col. 22 & Col. 23)			
w. Paramedical Education (Cols. 24, 25, & 26)			
2. Total Allocated General Service Costs (Sum Lines 1a - 1w)			(DMA-HB3, Line 1b)
3. Total Allocated Core General Service Costs (Amount of Line 2 applicable to Core Costs) (Providers Records)			
4. Total Allocated Non-Core General Service Costs (Line 2 - Line 3)			(DMA-HB4, Line 3)
5. Ratio of Core General Service Costs / Total General Service Costs (Line 3 / Line 2) Round to two (2) decimal places.			(Lines 1a -1w, Column 2)

* See (*) Note on DMA-HB1

CORE PROVIDER NO.	COST OF MEDICAID CORE SERVICES 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	FYE 2005
1. Total Core Services Cost	
a. Direct (DMA-HB1, Line 4, Col. 2)	
b. Indirect (DMA-HB2, Line 2, Col. 3)	
c. Total (Line 1a + 1b)	
2. Total Visits (Provider Records)	
3. Cost Per Visit (Line 1c / Line 2)	

	2004 (1)	2005 (2)	TOTAL (3)
4. Medicare Upper Payment Limit Per Visit (per HCFA Transmittal A-99-8)			
5. Medicaid Rate Covered Visits (Lessor of Lines 3 and 4)			
6. Medicaid Covered Visits for Core Services (Provider Records)			
Excluding Mental Health Services			
7. Medicaid Cost for Core Services (Line 5 x 6)			
8. Medicaid Covered Visits for Mental Health Services (Provider Records)			
9. Medicaid Covered Cost for Mental Health Services (Line 5 x 8)			
10. Total Medicaid Cost for Core Services (Line 7 + 9)			

CORE PROVIDER NO.	ALLOCATION OF OVERHEAD COST 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Cost Per DMA-HB1 (2)	Overhead Cost (Line 4, Col 2 x Lines 1a-1i Col 2) (3)	Total Cost (Col 2 + 3) (4)	Total Encounters/ Units of Service (Provider Records) (5)	Cost Per Encounter (Col 4 / 5) (6)
1. RHC/FQHC Ambulatory Services					
a. Pharmacy *					
b. Dental **					
c. Healthcheck Services (Formerly EPSDT)**					
d. Maternity Care Coordination ***					
e. Child Services Coordination ***					
f. Radiology Services (on-site) ***					
g. Norplant Services **					
h. Physician Hospital Services ***					
i. Other (Specify) ***					
2. Total Cost (Lines 1a-1i)					
3. Overhead Cost (DMA-HB2, Line 4)					
4. Unit Cost Multiplier (3 / 2)					

* Number of prescriptions
** Number of Encounters
*** Number of Units of Service

CORE PROVIDER NO.	DETERMINATION OF MEDICAID REIMBURSEMENT 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Cost Per Encounter (From DMA-HB4) (2)	Medicaid Encounters (Provider Records) (3)	Medicaid Cost (Col 2 x 3) (4)	
1. RHC/FQHC Services				
a. Pharmacy				
b. Dental				
c. Healthcheck Services (Formerly EPSDT)**				
d. Maternity Care Coordination				
e. Child Services Coordination				
f. Radiology Services (on-site)				
g. Norplant Services				
h. Physician Hospital Services				
i. Other (Specify)				
2. Subtotal				
3. Medicaid Core Service Cost				(DMA-HB3, Line 10)
4. Medicaid Cost of Pneumococcal and Influenza Vaccine				(DMA-HB8, Line 4)
5. Total Reimbursable Cost (Line 2 + 3 + 4)				
6. Amount Received/Receivable from Medicaid (Provider Records)				(DMA-HB6, Line 4)
7. Amount Due Provider <Program> Exclusive of Bad Debts (Line 5 - 6)				
8. Reimbursable Bad Debts				(DMA-HB7, Line 5)
9. Total Amount Due Provider (Program) (Line 7 + 8)				

CORE PROVIDER NO.	SUMMARY OF MEDICAID PAYMENTS 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Amount * Received / Receivable (Provider Records) (2)	Provider Number/s (3)	
1. RHC/FQHC Payments			
a. Pharmacy			
b. Dental			
c. Healthcheck Services (Formerly EPSDT) .			
d. Maternity Care Coordination			
e. Child Services Coordination			
f. Radiology Services (on-site).			
g. Norplant Services			
h. Physician Hospital Services			
i. Other (Specify)			
2. Core Services			
3. Third Party Liability			
4. Total Medicaid Payments			(DMA-HB5, Line 6)

*** Note:** Do Not Include:

Co-Payments billed for Core Services
Fees billed for Carolina Access
Medicare Crossover Payments

*** Note:** Include: Co-Payments billed for Ambulatory Services

CORE PROVIDER NO.	BAD DEBTS 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Amount (2)	
1. Co-Payment Billed to Medicaid Patients (Provider Records)		
2. Co-Payment Amounts Received From Medicaid Patients (Provider Records)		
3. Medicaid Bad Debts (Line 1 - 2)		
4. Less Medicaid Bad Debt Recoveries (Provider Records)		
5. Net Bad Debts (Line 3 - 4)		(DMA-HB5, Line 8)

CORE PROVIDER NO.	COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Pneumococcal (2)	Influenza (3)
1. Cost Per Pneumococcal and Influenza Vaccine Injection (Provider Records)		
2. Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicaid Beneficiaries (Provider Records) . .		
3. Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Line 1 x 2)		
4. Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Sum of Line 3, Columns 2 and 3) Transfer to Schedule DMA-HB5, Line 4		

CORE PROVIDER NO.	PPS RECONCILIATION SCHEDULE 2005 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	Encounters		
a. Core Services			
b. Dental			
c. EPSDT			
d. Norplant			
e. Home Health			
1. Total Encounters (Sum of Lines a-e)			
2. PPS Rate			
3. Total Prospective Payments with PPS Rate (Line 1 x 2)			
4. Total Reimbursable Cost from DMA-HB5			(DMA-HB5, Line 5 + DMA-HB5, Line 8)
5. Greater of PPS Payment or Reimbursable Cost			**Cost Settlement**
6. Amount Received from Medicaid			(DMA-HB6, Line 4)
7. Gross Amount Due Provider <Program>*			(Line 5 - Line 6)

* Amount due Program must be forwarded with As Filed Cost Report.

Settlement is in accordance with North Carolina Medicaid State Plan Attachment 4.19-B Section 2.